



Speech and Language Clinical Services Intake Form

Date Completed: ___ / ___ / ___
Site Requested: ___ Seattle ___ Tacoma

Person Completing this Form

Name: _____
Last First ___ Parent ___ Guardian ___ Other: _____

Client Information

Client Name: _____

Date of Birth: ___ / ___ / ___

Please answer the following questions about the client's living situation:

A. Are the client's parents Divorced/Separated? ___ No ___ Yes
1) If Divorced/Separated:
Who is responsible for making medical decisions for the client? ___ Joint ___ Sole
If sole custody, please specify which parent: _____
With whom does the client reside? _____

B. Household 1: _____ % time
Name of Parent or Guardian #1: _____
Name of Parent or Guardian #2: _____
Names, ages, and relation to client of all other individuals in the home:

C. Household 2: _____ % time
Name of Parent or Guardian #1: _____
Name of Parent or Guardian #2: _____
Names, ages, and relation to client of all other individuals in the home:

Are both parents aware of services being sought at the Autism Center? ___ No ___ Yes
Does your client have a Guardian Ad Litem? ___ No ___ Yes
If Yes, please provide their name: _____

D. Names and ages of any other siblings:

E. Primary Language: English Other: Specify _____
Percent time client is exposed to non-English language(s): _____ %
Length of exposure to English: _____ Non-English language: _____
Context of exposure (e.g., home, school) to English: _____ Non-English language: _____

F. Family History: Is there any known or suspected family history of any speech/language, behavior, learning, or physical development concerns? ___ No ___ Yes ___ Unsure



Speech and Language Clinical Services Intake Form

Date Completed: __ / __ / __
Site Requested: __ Seattle __ Tacoma

Concerns

1. Describe current concerns regarding speech and language/communication abilities.

2. Are there concerns regarding:
 - a. Understanding language: __ Yes __ No If yes, specify: _____
 - b. Speaking/talking: __ Yes __ No If yes, specify: _____
 - c. Social communication/peer interaction: __ Yes __ No If yes, specify: _____
 - d. Using specific sounds (e.g., "r"):
 __ Yes __ No If yes, specify: _____
 - e. Other: __ Yes __ No If yes, specify: _____
3. What do you hope to gain from a speech and language evaluation?

4. Does the client exhibit verbal scripting (frequently repeats phrases from books, TV or environment)? If yes, is this expression communicative/an appropriate response to their environment?

5. Does the client repeat words or phrases that are said to them (echolalia)?

6. Does the client have problems with feeding/eating (e.g., a restricted diet, sensitivity to specific textures or types of food, being a picky eater)?

Medical History

1. Were there any complications during pregnancy, or during/after birth? __ No __ Yes
If yes, please specify. _____
2. Has the client had any hospitalizations or surgeries, or other medical concerns? __ No __ Yes
If yes, please specify. _____
3. Does the client take any medications? __ No __ Yes If yes, what: _____



Speech and Language Clinical Services Intake Form

Date Completed: ___ / ___ / ___
Site Requested: ___ Seattle ___ Tacoma

- 4. Does the client have any allergies or dietary restrictions? ___ No ___ Yes If yes, what: _____
- 5. Are there any concerns regarding hearing? ___ No ___ Yes
When and where was the client's hearing most recently tested? Date: _____ Where: _____
- 6. Are there any concerns regarding vision? ___ No ___ Yes When
and where was the client's vision most recently tested? Date: _____ Where: _____

Speech and Language Developmental History and Current Skills

- 1. Please indicate the age at which the following developmental milestones were reached:
 - a. Babbling: _____
 - b. First words other than mama or dada: _____
 - c. First word combinations/phrases: _____
- 2. Does the client currently demonstrate the following skills:
 - a. Respond to his/her name: ___ Always ___ Sometimes ___ Never
 - b. Follow directions: ___ None ___ 1-step ___ 2-step Example: _____
 - c. Answer questions: ___ Choice ___ Yes/No ___ "Wh" (e.g., what, where, who)
 - d. Communicate using primarily: ___ Body movements and gestures ___ Single words ___ Phrases and sentences ___
Other (e.g., AAC device) (please specify): _____
 - e. How many words does the client use? ___ 0-20 ___ 20-50 ___ 50-100 ___ 100+
 - f. What percentage of the client's speech do you understand? ___% What percentage do others understand? ___%
 - g. How does the client interact (e.g., playing, talking) with peers? _____

If appropriate for your child, complete the following questions:

- 1. Does your child take at least 5 conversational turns (child + communication partner = 1 turn) with preferred topics? ___ Yes ___ No If not, how many turns: _____
- 2. Does your child retain employment or volunteer consistently (e.g., at the library, Goodwill)? ___ Yes ___ No
If so, please describe work and/or volunteer responsibilities:

- 3. Are there communication or other difficulties that impede his/her work or volunteer responsibilities?
___ Yes ___ No If yes, please describe:

- 4. Does the client exhibit difficulties identifying emotions or perspective taking of others? ___ Yes ___ No
If yes, please describe:

- 5. Does the client maintain friendships with similar aged peers? ___ Yes ___ No



Speech and Language Clinical Services Intake Form

Date Completed: ___ / ___ / ___
Site Requested: ___ Seattle ___ Tacoma

Where? ___ School/Work ___ Outside of Structured Settings ___ Both

Please describe these relationships:

Previous Evaluations and Treatment

1. Are there any other medical or mental health disorders that the client has been diagnosed with or in the process of being diagnosed? (e.g., ADHD, ODD, Down Syndrome, GI issues)

If so, please list below, and include year diagnosed:

2. Has the client ever been evaluated or received treatment from a speech therapist, occupational therapist, ABA provider, psychologist, physical therapist, special educator, or other therapist? ___ No ___ Yes

If yes, please provide the following information:

A. Name: _____ Type of specialist: _____

Date(s) of evaluation/treatment: _____

Purpose and results of evaluation/treatment: _____

B. Name: _____ Type of specialist: _____

Date(s) of evaluation/treatment: _____

Purpose and results of evaluation/treatment: _____

C. Name: _____ Type of specialist: _____

Date(s) of evaluation/treatment: _____

Purpose and results of evaluation/treatment: _____

Educational History

7. Is the client currently enrolled in school or Birth-3 Services? ___ No ___ Yes ___ N/A

School Name: _____ School District: _____

Program or Grade level: _____

8. Please list any other schools that the client has attended:

A. School Name: _____ School District: _____

Years of attendance: _____ Grade Levels: _____

B. School Name: _____ School District: _____

Years of attendance: _____ Grade Levels: _____

C. School Name: _____ School District: _____



Speech and Language Clinical Services Intake Form

Date Completed: __ / __ / __
Site Requested: __ Seattle __ Tacoma

Years of attendance: _____ Grade Levels: _____

- 9. Is the client receiving or has the client received special services or accommodations at school? ___ No ___ Yes
 - A. If yes, please explain what type (e.g., IEP, IFSP, 504 Plan) and what type(s) of services received (e.g., communication, cognitive, social/emotional, fine/gross motor, reading, math).

Client's Interests

- 1. Preferences (favorite activities/toys, food, interests/topics, sensory activities):

- 2. Dislikes (aversions):

- 3. Other important information:

Additional Comments

Evaluations/Assessment Reports

Please attach a copy of the client's reports (select attached)

- Diagnostic Evaluation Report
- IEP/IFSP/504 Plan
- Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)
- Other: _____
- Other: _____
- Other: _____



Speech and Language Clinical Services Intake Form

Date Completed: __ / __ / __
Site Requested: __ Seattle __ Tacoma

Hours of Availability

Please mark the times you and the client **ARE** available for services.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					